Correspondence

The Editors will be pleased to receive and consider for publication correspondence containing information of interest to physicians or commenting on issues of the day. Letters ordinarily should not exceed 600 words and must be typewritten, double-spaced, and submitted in duplicate (the original typescript and one copy). Authors will be given the opportunity to review the editing of their correspondence before publication.

Decriminalizing Drug Use

To THE EDITOR: It is becoming increasingly clear that attempting to enforce a ban on certain illegal psychoactive substances through conventional law enforcement and court procedures is not possible without abrogating our long-standing individual protections under the Bill of Rights. Furthermore, it is exorbitantly wasteful and ineffective. It must also be recognized that alternative proposals dealing with the problem of harmful drug use have been few and lack specificity. In a recent debate on public television, proponents of legalization had no appropriate answers to Representative Charles Wrangel (Democrat, New York City), who wanted to know which drugs would be legally distributed, under what circumstances, and by whom.

I think that as a society we would be best served by pursuing a policy of selective decriminalization (not legalization) in an attempt to ameliorate the ravages of drug use. Laws pertaining to the sale or distribution of psychoactive substances would remain in effect. The *use* of psychoactive substances would no longer be a crime, but the user would be required to enter into a treatment program under medical management.

It is time to admit that we do not have a single solution to the problem of illegal drug use in our society. Selective decriminalization combined with medical intervention should be tried (even though treatment regimens are not proven effective) but only after a consensus is reached on how to best answer Representative Wrangel's excellent questions.

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The 'Aerospace Syndrome'

To THE EDITOR: I appreciate Dr Terr's editorial[1] in response to our article, "An Outbreak of Illness in Aerospace Workers,"[2] in the July issue and heartily concur with his analysis overall.

I am writing to clarify, as well as amplify with additional data, some of the points in the article. In the editorial Dr Terr commented that the "aerospace syndrome" apparently fit well into the category of illness previously described as "multiple chemical sensitivity."[1] In fact, only a subgroup (15) of the 53 workers described in our article actually met the previous definition of this syndrome.

This subgroup had a strikingly high prevalence of preexisting anxiety and depressive disorders, as described in a companion article.[3] Many of the other workers, who did not appear to meet the definition for "multiple chemical sensitivity," improved after being removed from exposure over the long term to phenol-formaldehyde composite materials. This suggests that psychological vulnerability may influence the chronicity of symptoms associated with the incident.

Not mentioned in detail in our article is the fact that the company made air measurements of phenol and formaldehyde in the workplace shortly after introducing the phenol-formaldehyde composite material. Levels were well below permissible exposure limits.

Low-level exposure to odors or respiratory tract irritants may stimulate the olfactory or trigeminal nerves, or both, and produce autonomic arousal,[1,4] perhaps through a mechanism involving the limbic system. The expression of illness is clearly multifactorial, and chemical exposure and odor alone probably are not sufficient to cause this and other similar outbreaks of illness. Nevertheless, given other psychosocial factors—which have yet to be clearly identified and measured—such low level irritant or olfactory stimulation may result in definite illness with features typical of acute anxiety and depression.[2] It is also possible that such symptoms may be due primarily to psychosocial factors and have little to do with chemical exposure at all.

The intense reluctance of patients, the public, and many health care practitioners to acknowledge the likely psychophysiologic nature of the illness in similar outbreaks of workplace illness attributed to environmental exposure may be because of the perception that psychological symptoms are somehow less "real" or legitimate expressions of illness. Also, the workers' compensation, legal, and administrative systems are less likely to accept or pay for treatment of psychological illness or injury, especially when the etiology is likely to be multifactorial and not attributable primarily to any direct "toxic" effect of individual or mixed chemical exposures.

The industrial hygienists who measure the air, the chemists who evaluate the chemical components of materials and processes, and the physicians who evaluate persons affected by similar outbreaks of illness are each looking at a piece of the elephant, and we have yet to clearly define the entire shape of the problem.

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Herpes Zoster Ophthalmicus—The Changing Epidemiology and Its Implications for Treatment

To THE EDITOR: Immunocompromised patients with herpes zoster ophthalmicus (HZO) are at risk for the development of disseminated disease as well as ocular complications.[1,2] Before 1983, we saw approximately six patients a year with HZO at the San Francisco General Hospital Medical Center (SFGH) Eye Clinic, a clinic with about 9,000 visits a year;